

**SAMPLE PRIOR AUTHORIZATION LETTER TO
INSURANCE COMPANY/PLAN
(To Be Completed By Physician Or Lactation Consultant)**

Date

Payer Name
Payer Address
City, State, Zip

Patient First/Last Name:
Insured Name:
Policy Number:

Dear Claims Representative:

This letter serves as a request for prior authorization for (INSERT BREASTFEEDING COUNSULTATIONS, EQUIPMENT AND/OR SUPPLIES) for the above named patient. The following information about the patient's medical history and diagnosis, the medical necessity of this treatment and the treatment plan will show the appropriateness of this request.

This patient's child, (INSERT CHILD'S NAME), was born into the high-risk category on (INSERT CHILD'S BIRTHDAY). He/She has not been able to successfully breastfeed due to (ILLNESS OR PREMATURITY). (INSERT ANY OTHER SUPPORTIVE MEDICAL INFORMATION SPECIFIC TO THIS PATIENT). It is important that this mother is able to pump her breasts in order to provide her infant with breast milk, which provides optimal nutritional value at this vital stage of life. This pumping also allows the mother to continue having an adequate supply of breast milk so that once the baby becomes stronger he/she can begin or resume nursing at the breast.

I have recommended breastfeeding for this mother and infant according to the guidelines established by the American Academy of Pediatrics which states, "Human milk is species-specific, and all substitute feeding preparations differ markedly from it, making human milk uniquely superior for infant feeding. ... Pediatricians and parents should be aware that exclusive breastfeeding is sufficient to support optimal growth and development for approximately the first 6 months of life. Breastfeeding should be continued for at least the first year of life and beyond for as long as mutually desired. ... Hospitals and physicians should recommend human milk for premature and other high-risk infants either by direct breastfeeding and/or using the mother's own expressed milk."¹

I am recommending (NUMBER) appointments with this patient over the next (AMOUNT OF TIME). Listed below is the breastfeeding equipment that is necessary for this patient:
(LIST ITEMS)

Please forward your prior authorization for this service to me at: (INSERT FAX NUMBER OR ADDRESS). Thank you for your consideration. Please contact me if you have any questions.

Sincerely,

Provider Name, Address and Phone Number

¹ PEDIATRICS Vol. 115 No. 2 February 2005, pp. 496-506 (doi:10.1542/peds.2004-2491)